North Carolina Department of Health and Human Services
Division of Medical Assistance
AGREEMENT FOR PARTICIPATION AS A PRIMARY CARE PROVIDER IN NORTH CAROLINA'S PATIENT ACCESS AND COORDINATED CARE PROGRAM (CAROLINA ACCESS)

This agreement is between the State of North Carolina, Department of Health and Human Services Division of Medical Assistance, whose principal office is located in the City of Raleigh, County of Wake, State of North Carolina, hereinafter referred to as the "Division"

and *_____ (Name of Primary Care Provider) located in the city of *_____,

county of *_____, State of North Carolina or State of _____

hereinafter referred to as the "Contractor."

WHEREAS, the Division, as the single State agency designated to establish and administer a program to provide medical assistance to the indigent under Title XIX of the Social Security Act, is authorized to contract with health care providers for the provision of such assistance on a coordinated care basis;

NOW, THEREFORE, it is agreed between the DIVISION and the CONTRACTOR, as follows:

I. General Statement of Purpose and Intent

The Division desires to contract with providers willing to participate in the North Carolina Medical Assistance Program (Medicaid) to provide primary care directly and to coordinate other health care needs through the appropriate referral and authorization of Medicaid services. This program, Carolina ACCESS, applies to certain Medicaid recipients who may select or be assigned to the Contractor. This agreement describes the terms and conditions under which this agreement is made and the responsibilities of the parties thereto.

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

II. General Statement of the Law

North Carolina's Patient Access and Coordinated Care Program (Carolina ACCESS) is a primary care patient coordination system implemented pursuant to Title XIX of the Social Security Act, and is subject to the provisions of North Carolina Statutes and North Carolina Administrative Code. This agreement shall be construed as supplementary to the usual terms and conditions of providers participating in the Medicaid program, except to the extent superseded by the specific terms of this agreement. The Contractor agrees to abide by all existing laws, regulations, rules, policies, and procedures pursuant to the Carolina ACCESS and Medicaid program.

The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, are governed by the laws of North Carolina. The Contractor, by signing this Contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the only venue for any legal proceedings shall be Wake County, North Carolina. The place of this Contract, and all transactions,

agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation, and enforcement, shall be determined.

III. Definitions-The following terms have the meaning stated for the purposes of this agreement:

Application- All forms and supplements to this agreement that the provider uses to apply for participation with the Carolina ACCESS program. This agreement shall be effective subject to approval of the Application by the Division.

Carolina ACCESS Policy- All policies and procedures required by this agreement and incorporated herein by reference are published in the *General Medicaid Billing Guide* which is published on the Division's website at http://www.dhhs.state.nc.us/dma/.

C.F.R- Code of Federal Regulations.

Contractor- The Primary Care Provider (PCP) entering into this agreement with the Division of Medical Assistance.

Division- The Division of Medical Assistance of the North Carolina Department of Health and Human Services.

Eligible Recipient- Medicaid recipients who are enrolled in the Carolina ACCESS program.

Enrollee- A Medicaid recipient who chooses or is assigned to a Carolina ACCESS primary care provider.

Group Practice/Center- A Medicaid participating primary care provider structured as a group practice/center which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as a group by means of a Medicaid Group Provider number.

Management/Coordination Fee- The amount paid to the Contractor per member per month for each Carolina ACCESS recipient who has chosen or has been assigned to the Contractor.

Medicaid- The North Carolina Medical Assistance Program.

Medically Necessary- The term "Medical Necessity" is defined by Division policy.

Patient Care Coordination- The manner or practice of providing, directing, and coordinating the health care and utilization of health care services of enrollees with regard to those services as defined by Carolina ACCESS Policy that must be authorized by the primary care provider. If not provided directly, necessary medical services must be arranged through the primary care provider.

Potential Enrollee- A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Primary Care Provider.

Preventive Services- Services rendered for the prevention of disease in adults and children as defined by Carolina ACCESS Policy.

Primary Care- The ongoing responsibility for directly providing medical care (including diagnosis and/or treatment) to an enrollee regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients, and referring the enrollee to another provider when necessary.

Primary Care Provider- The participating physician, physician extender (PA, FNP, CNM), or group practice/center selected by or assigned to the enrollee to provide and coordinate all of the enrollee's health care needs and to initiate and monitor referrals for specialized services when required.

Recipient Disenrollment- The deletion of the individual from the monthly list of enrollees furnished by the Division to the Contractor.

Women, Infants, and Children (WIC) Program- The Special Supplemental Food Program created by Congress in 1972 to meet the special nutritional needs of pregnant, breastfeeding and postpartum women, and of infants and children up to age five (5).

IV. Functions and Duties of the Contractor

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

The Contractor is and shall be deemed to be an independent Contractor in the performance of this Contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

The Contractor shall not subcontract any of the work contemplated under this Contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors specified in the Contractor's application are to be considered approved upon award of the contract. The Contractor shall be responsible for the performance of any subcontractor. The Division shall not be responsible to pay for work performed by unapproved subcontractors.

The Carolina ACCESS Contractor agrees to do the following:

4.1 Accept enrollees pursuant to the terms of this agreement and be listed as a primary care provider in the Carolina ACCESS program for the purpose of providing care to enrollees and managing their health care needs.

4.2 Provide Primary Care and Patient Care Coordination services to each enrollee in accordance with the provisions of this agreement and the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Carolina ACCESS Policy.

4.3 Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Carolina ACCESS Policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

4.4 Provide direct patient care a minimum of 30 office hours per week or as defined by Carolina ACCESS Policy.

4.5 Provide preventive services as defined by Carolina ACCESS Policy.

4.6 Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Carolina ACCESS Policy.

4.7 Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Carolina ACCESS Policy.

4.8 Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. Provide the authorization number (Carolina ACCESS provider number) to the referral provider either in writing or by telephone as defined by Carolina ACCESS Policy.

4.9 Transfer the Carolina ACCESS enrollee's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request.

4.10 Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Carolina ACCESS Policy.

4.11 Refer for a second opinion as defined by Carolina ACCESS policy.

4.12 Review and use all enrollee utilization and cost reports provided by the Carolina ACCESS Program for the purpose of practice level utilization management and advise the Division of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Carolina ACCESS Policy. A signed Provider Confidential Information and Security Agreement is required for online access to these reports. The form is published on the Division's web page at http://www.dhhs.state.nc.us/dma.

4.13 Participate with Division utilization management, quality assessment, and administrative programs.

4.14 Provide the Division or its duly authorized representative or the Federal government unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

4.15 Refer potentially eligible enrollees to the WIC Program with the enrollee's consent to the release of relevant medical record information.

4.16 Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the North Carolina Physicians Advisory Group.

4.17 Notify the Division or its agents of any and all changes to information provided on the initial application for participation.

4.18 Give written notice of termination of this contract, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.

4.19 Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

4.20 Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

4.21 Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

4.22 Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

4.23 Receive prior approval from the Division of any marketing materials prior to distribution. Marketing materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits. Marketing materials shall not make any assertion or statement that the Contractor is endorsed by CMS, the Federal or State government or similar entity.

4.24 Refrain from door-to-door, telephonic or other 'cold-call' marketing; engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the Contractor, its marketing representatives, or the Division.

4.25 Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the Contractor,
- A person with beneficial ownership of more than five percent (5%) or more of the Contractor's equity; or,
- A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's contractual obligation with the Division.

4.26 Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends.)

V. Functions and Duties of the Division

The Division agrees to do the following:

5.1 List the Contractor's name as a primary care provider in the Carolina ACCESS program.

5.2 Pay the Contractor on a fee-for-service basis in accordance with the Medicaid fee schedule and billing guidelines. Any monthly management/coordination fee paid in addition to the fee-for-service Medicaid payments will be paid per member per month, subject to the maximum number of enrollees under paragraph 6.1.A. The amount of the management/coordination fee, if any, may be adjusted according to practice performance parameters as defined by the Division. Multiple providers within a group practice are considered a single entity for purposes of the management/coordination fee.

5.3 Provide the Contractor with a monthly list of enrollees who have selected or have been assigned to him/her for the purpose of managing their health care needs.

5.4 Provide training and technical assistance regarding the Carolina ACCESS program.

5.5 Provide the Contractor with periodic utilization and cost reports.

5.6 Gather and analyze data relating to service utilization by enrollees to determine whether Contractors are within acceptable Carolina ACCESS peer comparison parameters.

5.7 Publish the *General Medicaid Billing Guide* and the Medicaid General and Special Bulletins on the Division's website at http://www.dhhs.state.nc.us/dma. All such policies, procedures, Medicaid provider bulletins and manuals are incorporated into this agreement by reference.

5.8 Provide an ongoing quality assurance program to evaluate the quality of health care services rendered to enrollees.

5.9 Provide program education to all enrollees through the local Department of Social Services or duly authorized representatives during eligibility reviews or within a reasonable timeframe. The recipient will receive accurate oral and written information needed to make an informed decision on whether to enroll.

5.10 Provide potential enrollees and enrollees with the *Carolina ACCESS Medicaid Managed Care Recipient Handbook* that contains program information including enrollee rights and protections, program advantages, enrollee responsibilities, complaint and grievance instructions. The *Carolina ACCESS Medicaid Managed Care Recipient Handbook* is also published on the Division's website at http://www.ncdhhs.gov/dma/ca/.

5.11 Notify enrollees that oral interpretation is available for any language and written material is available in prevalent languages and how to access these services.

5.12 Provide written materials that use easily understood language and format. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

5.13 Inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

5.14 Provide marketing materials to potential enrollees.

VI. General Terms and Conditions

6.1 Recipient Enrollment and Disenrollment

A. Recipient Enrollment

The Contractor must accept individuals in the order in which they apply without restriction up to the limits set by the contract. The Contractor may specify a limit on the number of enrollees on the Carolina ACCESS Application for Participation subject to the following terms and conditions:

- Maximum enrollment is set at 2,000 enrollees per physician or physician extender unless otherwise approved by the Division.
- Notwithstanding the enrollment limits specified above, the Contractor may receive an enrollment that slightly exceeds these limits due to the nature and timing of the enrollment process.
- The Contractor may set enrollment criteria on the Application, but must accept recipients who meet the enrollment criteria up to the limit specified.
- The Contractor may change the enrollee limit by notifying the Division.
- The Contractor must restrict enrollment to recipients who reside sufficiently near the delivery site to reach that site within a reasonable time using available and affordable modes of transportation.

B. Recipient Choice

1. Eligible Recipients may choose from among participating Contractors who are available to their county of residence when those Contractors' enrollment limits have not been exceeded.
2. Eligible Recipients who do not choose a primary care provider shall be assigned to an appropriate participating provider available to their county of residence based on historic usage, location and/or randomly by rotating assignment.
3. All recipient enrollments, disenrollments and changes are effective on the first day of the month, pursuant to processing deadlines and will be indicated on the Enrollment Report.

C. Recipient Disenrollment

1. Enrollees shall be permitted to change primary care providers according to Carolina ACCESS Policy. Transfer of medical records is addressed in Section 4.9 of this agreement.
2. The Contractor may request the disenrollment of an enrollee for good cause as defined by Carolina ACCESS Policy.
3. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees).
4. The Carolina ACCESS Medicaid Managed Care Recipient Handbook includes complaint and grievance instructions and is provided to potential enrollees and enrollees. This handbook is also published on the Division's website at http://www.dhhs.state.nc.us/dma/.
5. If the Division fails to make a disenrollment determination so that the recipient can be disenrolled no later than the first day of the second month following the month in which the recipient or the Contractor files the request, the disenrollment is considered approved.

6.2 Contract Violation Provisions

The failure of a Contractor to comply with the terms of this agreement may result in the following sanctions by the Division:

A. Limiting member enrollment with the Contractor.

B. Withholding all or part of the Contractor's monthly Carolina ACCESS management/coordination fee.

C. Referral to DMA Program Integrity Unit for investigation of potential fraud or quality of care issues.

D. Referral to North Carolina Medical Board.

E. Termination of the Contractor from the Carolina ACCESS program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Division based on the severity of the agreement violation. The Division makes the determination to initiate sanctions against the Contractor. The Contractor will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Division determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the Contractor disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Carolina ACCESS Policy.

Failure of the Division to impose sanctions for an agreement violation does not prohibit the Division from exercising its rights to do so for subsequent agreement violations.

Federal Financial Participation (FFP) is not available for amounts expended for Contractors excluded by Medicare, Medicaid or State Children's Health Insurance Program (SCHIP), except for emergency services.

6.3 Application Process

The Contractor will complete an Application to submit with the signed agreement for review and approval by the Division.

6.4 Exceptions to the Agreement

The Division may approve exceptions to this agreement if, in the opinion of the Division, the benefits of the Contractor's participation outweigh the Contractor's inability to comply with a portion of this agreement.

In order to amend this agreement, the Contractor shall submit a written request to the Division for consideration for exception from a specific agreement requirement. The request shall include the reasons for the Contractor's inability to comply with this agreement requirement. The request shall be submitted at the time this agreement is submitted to the Division for consideration. Approval of the Application constitutes acceptance of the request for an exception.

6.5 Transfer of Agreement

This agreement may not be transferred.

6.6 Contract Termination

This agreement may be terminated by either party, with cause, or by mutual consent, upon at least thirty (30) days written notice delivered by certified mail with return receipt requested and will be effective only on the first day of the month, pursuant to processing deadlines.

The Division under the following conditions may terminate this agreement immediately:

1. In the event that state or federal funds that have been allocated to the Division are eliminated or reduced to such an extent that, in the sole determination of the Division, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from the Division; or

2. If the Contractor (a) is determined to be in violation of terms of this agreement, or applicable federal and state laws, regulations, and policy, and/or (b) fails to maintain program certification or licensure; or
3. Upon the death of the Contractor, the sale of the Contractor's practice, or termination of participation as a Medicaid or Medicare provider; or
4. In the event of conduct by the Contractor justifying termination, including but not limited to breach of confidentiality or any other covenant in this agreement, and/or failure to perform designated services for any reason other than illness.

The Contractor must supply all information necessary for reimbursement of outstanding Medicaid claims.

VII. Effective Date and Duration

This agreement shall become effective on _____ (to be completed by DMA office staff) and remain in effect until amended or terminated pursuant to the terms of this agreement.

VIII.Signatories:

*Signature of Authorized Official *Date

*Printed Name and Title

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

North Carolina Department of Health and Human Services/Division of Medical Assistance

Authorized Representative Title

Date